Flexible Spending Account Enrollment

King County
Benefits, Payroll and Retirement Operations

Complete this form to enroll in a health care FSA, dependent care FSA, or both, when you first become eligible for benefits. Return the form to Benefits, Payroll and Retirement Operations, The Chinook Building CNK-ES-0240, 401 Fifth Ave., Seattle WA 98104-2333 ***within 30 days after your hire date***. To have FSA reimbursements deposited directly to a bank or savings account, call WageWorks at 855-428-0446 or visit *www.wageworks.com*.

Name (print) _____ PeopleSoft Employee ID _____

Street Address or PO Box _____

City _____ State _____ ZIP _____

E-mail _____ Contact Phone (_____) _____

Health Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The minimum you may contribute is $300; the maximum may not exceed $2,500 annually.

☐ Yes, I elect to participate. Please deduct an **annual total** of $ _____ for calendar year 20 __ __.

Dependent Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The minimum you may contribute is $300; the maximum may not exceed: (1) the income of the spouse with the lowest income when under $5,000,
(2) $5,000 annually if married filing jointly or head of household or
(3) $2,500 annually if married filing separately

☐ Yes, I elect to participate. Please deduct an **annual total** of $ _____ for calendar year 20 __ __.

Authorization

I authorize King County to withhold a portion of my pre-tax employment compensation and deposit these funds to the FSA(s) I've designated above. In consideration of King County allowing me to participate in the plan, I agree to abide by the terms, conditions and provisions of the plan. I have been informed the plan may be modified from time to time and I agree King County may cancel or amend the plan according to its independent judgment and discretion. I understand I will be notified in advance of any changes.

I acknowledge the Internal Revenue Code and the plan permit me to claim reimbursement only for my eligible expenses incurred after the effective date of my FSA elections. I understand the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me by the plan. I assume full responsibility for all taxes, penalties, interest or other consequences, which may be assessed to or imposed on me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements from the plan for disallowed expenses.

I choose to participate in the FSA program with the knowledge that my salary reduction elections may reduce my FICA withholdings (Social Security) which may reduce my Social Security benefits upon retirement.

I understand I must claim reimbursement for eligible expenses incurred during the calendar year on or before 90 days after the last day of the year or I will forfeit those reimbursements. I also understand that I may not make any changes to my annual election unless I have a qualifying life event.

Health Care FSA: I understand that up to $500 of unused funds may be carried over for use in the following calendar year for eligible expenses.

Dependent Care FSA: I understand that I may file claims for eligible dependent care expenses as I incur them but I will not receive reimbursement until I have actually contributed the funds.

Signature _____ **Date Signed** _____

Office Use Only	Received Date Staff Name	Processed By Date Staff Name	Audit Date Staff Name	FSA Effective Date